Department of Business Regulation
233 Richmond Street
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Insurance Bulletin Number 2004-10

Regulation 73 Compliance

The following are clarifications of certain provisions of Regulation 73 with respect to which the Department has received inquiry.

Regulation 73(6)(A) provides in part that the insurer advise a claimant "…of the acceptance or denial of the claim…" from the date of "…receipt by the Insurer of properly executed proofs of loss…" The insurer is not excused from compliance with this section because it does not request a formal proof of loss in the handling of the claim. The term "proof of loss" for purposes of this section is the date on which the insurer has sufficient information regarding the loss to adequately apprise the insurer of the insured's claim to allow it to estimate its rights and liabilities. For purposes of compliance with the Regulation, the insurer has the burden of proving the date from which the timing requirement of Regulation 73(6) should be calculated if the date differs from the date the claim is reported to the insurer.

Regulation 73(6)(E) excuses the insurer from compliance if a claimant is "legally represented." The term "legally represented" in this context means that the claimant is represented by an attorney licensed to practice law in Rhode Island. The fact that the claimant may have retained a public adjuster for purposes of claim submission and negotiation does not excuse the insurer from compliance with the section. In order to be compliant with the Regulation, insurers must notify all claimants and insureds of the statute of limitations prior to beginning any discussions about the claim (inclusion in the acknowledgment letter under Regulation 73(5)(D) would satisfy this requirement) and again at least thirty (30) days for insureds and sixty (60) days for claimants prior to expiration of the statute of limitations.

Regulation 73(6)(I) requires that the insurer provide a specific notification upon the "…denial of a claim, in whole or in part…". This requires the insurer to make the notification any time the insurer has paid less than demanded, whether or not the insurer believes that full payment has been made under the policy. This includes claims where there is a dispute in value or where the insurer believes it has paid all benefits due under the policy.

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September 30, 2004